PRIORITY POPULATION REPORT

Introduction

Harborview Medical Center reports to the County on an annual basis the status of services to its priority populations. This year, the report serves a dual purpose. It will provide information on its priority populations and inform the Health Status and Health Systems Project on issues impacting both the population and the providers which serve them.

Harborview Medical Center (HMC) is owned by King County, governed by the Harborview Board of Trustees, and managed under contract by the University of Washington. HMC is a comprehensive health care facility whose primary mission is to provide and teach exemplary patient care to a broad spectrum of patients. In addition, it has a priority commitment to provide care to those patients identified as its mission population.

King County Ordinance 6818 requires that HMC Board of Trustees report to King County annually on the status of services to priority patient populations.

The following group of patients and programs, as noted in the King County Code, are priorities for HMC:

- **persons incarcerated in the King County Jail,**
- **mentally ill patients, particularly those treated involuntarily,**
- **persons with sexually transmitted diseases including HIV/AIDS,**
- **substance abusers,**
- **indigents without third party coverage and those eligible for Medicaid,**
- **non-English speaking poor,**
- **trauma cases,**
- **burn treatment,**
- **specialized emergency care,**
- **victims of domestic violence, and**
- **victims of sexual assault.**

In FY95, 79 percent of all inpatients discharged from HMC and 73 percent of all outpatients[1] met at least one priority patient category (Tables 1 and 2); many patients met two or more categories. The number of outpatient visits and inpatient discharges by priority populations demonstrate that the majority of resources at HMC are devoted to serving priority patients.

HMC provides a tremendous service to the county by serving both the specialized needs of the population and the needs of those who have few resources and options for care. Over thirty percent of King County's population with incomes below the poverty level came to HMC for care. It is the mission to the indigent population that makes HMC particularly vulnerable to changes in public policy and support as well as emerging trends in the health care industry.

[1] HMHS Activity Report, FY95.

Changes in the Broader Health Care system

HMC operates within the larger state and national health care system that has changed rather dramatically over the past decade and is still in a state of transition. Recent Health Status and Health Systems reports prepared by the Seattle-King County Department of Public Health and the community clinics outlines four trends in the health care system that significantly impact Harborview and its mission populations:

- The emergence of a more competitive health care system that places providers who serve large numbers of Medicaid and uninsured patients at a financial disadvantage
- An increase in the number of uninsured persons through both public policy changes and trends in the private sector.
- Changing demographics in the King County area with its concentration of higher risk populations, such as the homeless, non-English speaking and the mentally ill.
- A changed political climate where federal policy changes will impact State and local resources available to serve vulnerable populations and the public systems which serve them.

These trends all have bearing on the services available to Harborview's mission population. The challenges faced by Harborview and others in the health and social arena will be discussed in this report. Issues of mutual concern will be outlined in the hope that the Health Status and Healthy Systems Project and others working in this arena can work together to improve the health status of the communities we serve.

Presentation of Priority Population Report

This report has two sections. The focus of the first section will be on clinical services to the priority patient population; research and training will not be discussed unless they have direct bearing on patient care. Section One provides summary data on the priority patient population including discharge and visit data, patient demographics, and payors. It provides background information and pertinent issues for each priority patient population. Unless otherwise indicated, outpatient visits include the Emergency / Trauma Center (ETC), ambulatory care, and the Community Mental Health Center (CMHC). Section Two presents issues for future discussion that may effect all priority patient populations.

While data are presented by individual priority population, it is important to remember that the groups are not discreet or mutually exclusive. For instance, an individual can be low income and non-English speaking or a person with HIV/AIDS can also be a user of mental health services.

Section 1

Description of Priority Populations

Persons Incarcerated in the King County Jail

Introduction

Persons Incarcerated in the King County Jail, or more simply **jail inmates**, includes individuals who are in the custody of the King County Jail or on a Police Hold by any law enforcement agency in King County. It also includes juveniles placed under the jurisdiction of King County Juvenile Court and Detention Systems. The majority of jail inmates seen at HMC are from the King County Jail.

Patient Profile:

JAIL INMATE

John S. is a 30-year-old inmate of the King County Jail. He is serving three months on a burglary charge. He was brought to Harborview when he complained of difficulty in breathing and the Jail infirmary determined it was beyond their resources to help him. He was found to have an asthma exacerbation was evaluated in HMC's Emergency / Trauma Center(ETC) and admitted to 3-North for care. In less than a week he was able to be discharged from hospital care and return to the jail.

Patient Demographics

- *50% of jail inmates seen as inpatients at HMC are 30 years of age or younger.*
- *84% of jail inpatients seen at HMC are male.*
- *83% of inmates seen by HMC as inpatients have state or federal medical assistance as a payor source, the highest percentage of any priority population group; 39% of all jail inmates seen at HMC have the Medically Indigent Program as a payor source.*
- *11% of all jail inmates are at HMC because they have been involuntarily committed for mental health problems.*
- *16% of inmates who are inpatients at HMC live outside of King County.*

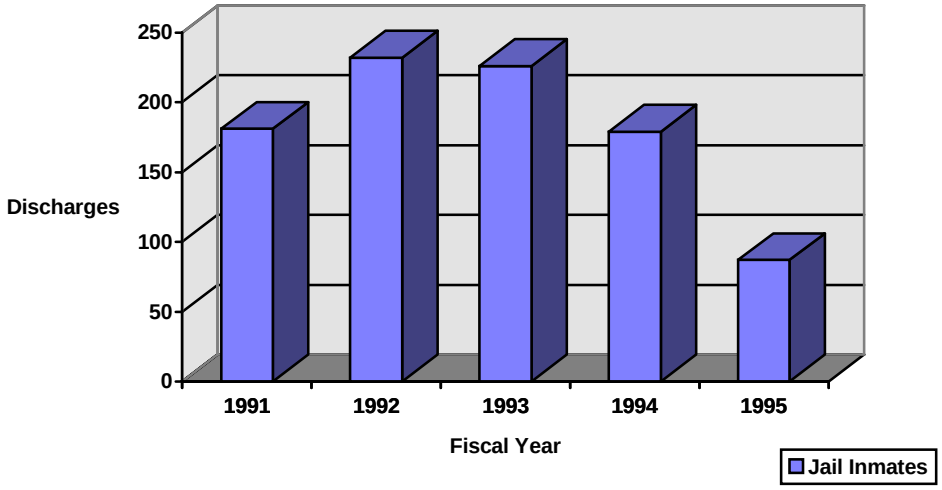
Services

In the King County Jail, all inmates are medically evaluated by a Registered Nurse when they are booked into the jail. Those with health issues are admitted to the jail infirmary (staffed by the SKCDPH) or, if injuries or illness are emergent in nature or require more sophisticated diagnostic evaluation and care, they are referred to HMC. At HMC, jail inmates can receive care as an outpatient, inpatient or in the Emergency and Trauma Center (ETC). Inmates have access to all services offered by HMC.

Visits/Discharges

HMC had 87 inpatient discharges of jail inmates in FY95; and 585 referrals of jail inmates to the ETC. Discharges of jail inmates represent less than 1% of all priority patient discharges from HMC in FY95.

The number of jail inmates discharged increased between FY91 and FY92, held steady in FY93, declined moderately in FY94, and dropped markedly in FY95. These declines are attributed to a new triage system and collaboration between HMC and King County staff that resulted in more care being provided at the jail and only the more serious cases being triaged to HMC.



Issues for Jail Inmate Population Services

- *As the funding for Medicaid and Medicare decreases, there will be less money to care for jail inmates, 83 percent of whom have state or federal medical assistance as a payor source and 9% Medicare.*

- *HMC is highly dependent upon the Medically Indigent (M.I.) program as a payor source, with 39% of jail inmates covered by the program. If the M.I. program experiences cutbacks by the State, it will have financial implications for HMC.*

Trauma and Specialized Emergency Care

Introduction

In December 1993, HMC was designated as the Level I Trauma Center for Washington State. In 1995, HMC, in collaboration with Children's Hospital and Medical Center, was designated a Level I Pediatric Trauma Center. These designations mean that HMC serves as the only Level I Adult and Pediatric Trauma Center for Washington, Alaska, Montana and Idaho.

Trauma patient outcomes are monitored through the Trauma Registry database and are compared with regional, statewide, and national scores. The data have consistently shown reduced morbidity and mortality for major trauma patients treated at Harborview.

Patient Profile:

TRAUMA
James M. is a 26-year-old teacher from Ellensburg. While driving on Interstate 90, he became involved in a multiple-car collision. He was stabilized at a nearby community hospital and then airlifted to Harborview where he underwent surgery for leg and pelvic fractures. He spent two weeks recovering on a Harborview inpatient floor, another ten days in a rehabilitation unit. His parents, also from central Washington, were grateful for the opportunity to stay at the Harborview Tower Apartments during the first critical week of his recovery.

Patient Demographics

- *77% of trauma cases seen on an inpatient basis at HMC are in people forty-five years of age and younger; 36% of trauma cases are under the age of 25. On an outpatient basis, approximately 32% of trauma patients receiving follow-up care are under 25 years of age.*

- *The majority of trauma admissions are male.*

- *64% of Emergency Trauma Center (ETC) outpatients come from within King County.*

- *40% of trauma inpatients have commercial insurance as compared to 22% of all patients admitted through the Emergency Department. Nearly 50% of trauma inpatients are covered by Medicaid (35%) or Medicare (12%) and 11% by other means. For Emergency Department patients overall,, self-pay is the largest payor category at 41%.*

Services

Harborview's ETC provides a 24 hour capability to provide care for the critically ill and injured including multiple, highly complex traumatic injuries, victims of sexual assault, those requiring care for complex psychiatric disorders as well as lesser injuries requiring immediate emergency treatment.

Harborview is also responsible for training paramedics in the region's Medic 1 and Emergency Medical Services systems.

The ETC provides:

- immediate surgical intervention;
- evaluation, and
- treatment including specialized comprehensive emergency care.

It utilizes an emergency communication system and emergency helicopter and fixed wing transport services through Airlift Northwest. HMC also relies upon Medic 1 for rapid stabilization and treatment in the field and transport of patients to the hospital[2].

Visits/Discharges

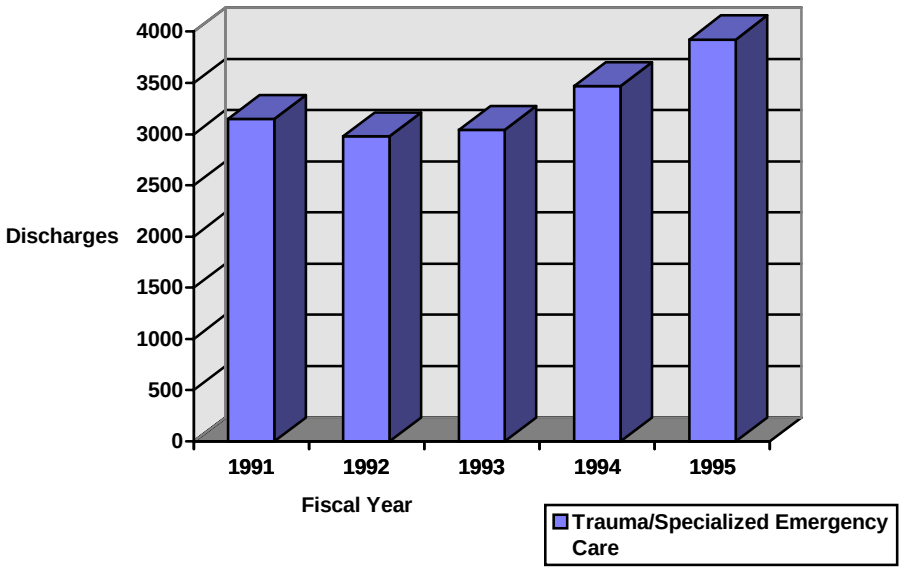
The Emergency / Trauma Center at HMC has an annual volume of approximately 44,678 patient visits, 15,991 for trauma, and generates over 69 percent of all admissions to the hospital.

In FY95, there were 3,924 patient discharges for trauma and specialized emergency care. This combined figure has risen since FY91, despite slight reductions in FY92 and FY93, and has now grown to over 30% of all HMC discharges.

The Emergency Department was named as one of the best performers in a recent University Hospital Consortium (UHC) survey. The survey ranked the department as outstanding in several areas including a low percentage of unscheduled returns, short times to disposition, and short times to admit.

The Intensive Care Unit was also recognized in a UHC study as a best performer in the country. It noted the ICU's declining mortality rate and low level of nosocomial infections.

[2] Specialized emergency care includes patients who received care in an intensive care unit (Coronary Intensive Care Unit, Medicine Intensive Care Unit, Neurosurgical Intensive Care Unit, and the Intensive Care [psychiatric] Evaluation Unit). It does not include patients with a principal diagnosis of burn or trauma, as those patients are served in the Trauma Intensive Care Unit (TICU) and the Burn Intensive Care Unit (BICU).



Expansion of the Urgent Care Clinic and HMC's Community Care Line with 24-hour nurse consult telephone assistance have relieved some pressure on the ETC enabling it to more effectively and appropriately serve seriously ill and injured patients.

As of March 1996, hospitals throughout the State were mandated to follow the state approved trauma plan. In the past, 25% of major trauma went to other hospitals in the Central Region (Seattle/King County) and 75% went to HMC; under the new plan, 86% of these patients would come to HMC, as the Level I Trauma Center.

Issues for Trauma and Specialized Emergency Care Services

- *The ETC is currently being used by the Seattle Police Department and other community agencies as a resource to triage people with mental health or substance abuse problems to services that may not be at HMC. There needs to be developed a less costly and more appropriate system of triage and referral.*
- *Coverage of severe trauma in the medically indigent will need to be investigated as the state's Medically Indigent Program has been funded through FY96 only and could be eliminated next biennium. Currently, 22% of the total State budget for the Medically Indigent Program goes to HMC. Potential loss of that funding would be significant to the indigent trauma patient and to HMC.*
- *Care of trauma patients is impacted dramatically by travel time between the site of the incident and the onset of trauma care. Transport time and a reduction in transfers for critically ill patients is needed. A new helipad and transport system into the trauma center would significantly impact health status. Funds are needed to construct this life-saving transport system.*
- *Trauma care can be improved structurally through the use of telemedicine and digital radiology. As the Level I Trauma Center for the state, HMC needs to improve its technology infrastructure to support trauma consultation statewide.*

Burn Patients

Introduction

As one of the largest burn centers in the United States, HMC has cared for more than 9,000 patients since it opened in 1974 with approximately 400 patients admitted annually. The University of Washington Burn Center at Harborview serves 94% of admissions in Washington State with diagnoses relating to burns. Ninety percent of these patients return to their previous lifestyles within a year of their injuries due to advances in burn treatment developed and pioneered at the Burn Center. Burn patient outcomes are monitored through the Burn Registry and the National Institute of Disability and Rehabilitation Research (NIDRR) study.

Patient Profile:

BURN PATIENTS
William L. is a 15-year-old student from Seattle who was working on the engine of the family car when a safety light exploded and ignited oil on the garage floor. Burned over 60 percent of his body, he was rushed to Harborview. He spent his first week in the Burn Intensive Care Unit (9N) and another three weeks on 8N, Burn/Plastics Unit. He will be returning to the Burn/Plastics outpatient clinic for at least a year for follow-up.

Patient Demographics

- *Nearly 50% of inpatient burn cases are 20 years of age or under and the majority of patients are male (67%); for outpatients, about 30% of cases are under 20 years of age.*

- *A large number of burn patients have commercial insurance (47% inpatient and 30% outpatient). Forty-one percent of inpatients and 34% of outpatients are covered by Medicare and Medicaid. Twenty-seven percent of inpatients come from outside King County.*

Services

The Burn Center includes the following services:

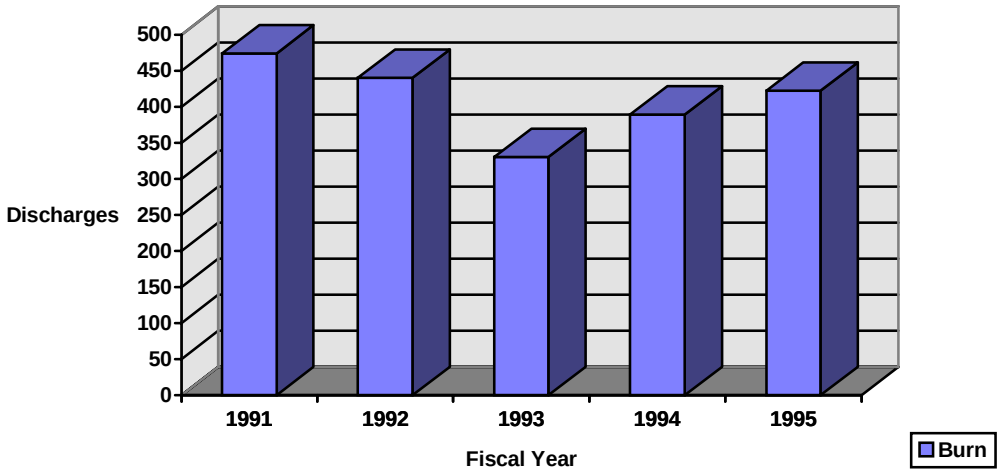
- general surgery,
- plastic and reconstructive surgery,
- intensive inpatient care,
- acute care,
- outpatient care,
- physical, occupational, recreational and vocational rehabilitation therapies,

- nutritional assistance,
- pain management,
- outpatient support groups,
- return to school and work programs,
- psychological interventions, and
- outreach / burn prevention programs.

Visits/Discharges

In FY95, there were nearly 3800 outpatient visits for burn patients.

From FY90 to FY95, the number of inpatient burn cases declined by approximately 11%. This is being attributed to high visibility prevention campaigns.



The average length of stay at HMC for burn patients is 9.3 days. HMC is the first hospital on the west coast to receive the American Burn Association / American College of Surgeons burn center verification as a designated regional burn center.

Issues for Burn Patient Services

- *Insuring that burn patients have proper treatment: Follow-up care for serious burns requiring a certain level of expertise and continuity may be compromised by managed care as the incentive is for the primary care providers to do follow-up care outside of a burn center program.*

Mentally Ill Patients

Introduction

HMC provides inpatient and outpatient care for those requiring mental health treatment. It is a certified outpatient mental health provider, one of approximately 20 in the county. Like other mental health providers, HMC participates in a prepaid health plan (PHP) for publicly funded patients.

Patient Profile:

MENTALLY ILL
Jane K. is a 27-year-old office assistant who has suffered from depression since her teenage years. Five years ago, when she seriously contemplated suicide, she briefly became a voluntary inpatient at Harborview. After being released, she was referred to ongoing counseling sessions. Currently, she is taking medication for her problem and no longer experiences mood swings. As an outpatient, she is making progress and has her depression under control enough to hold a part-time job and do volunteer work.

Patient Demographics

- *The mentally ill inpatient seen at HMC tends to be between 21 and 50 years of age (78%) and covered predominantly by Medicaid (65%) and Medicare (25%).*
- *58% of mental health inpatients are male.*
- *44% of mental health inpatients are from central King County.*
- *The outpatient statistics mirror the inpatient statistics in terms of age and gender.*

Services

HMC provides a complete spectrum of mental health services:

- emergency psychiatric care,
- crisis intervention, and
- outpatient and community mental health treatment, including both voluntary and involuntary treatment.

In addition, it provides specialty care including:

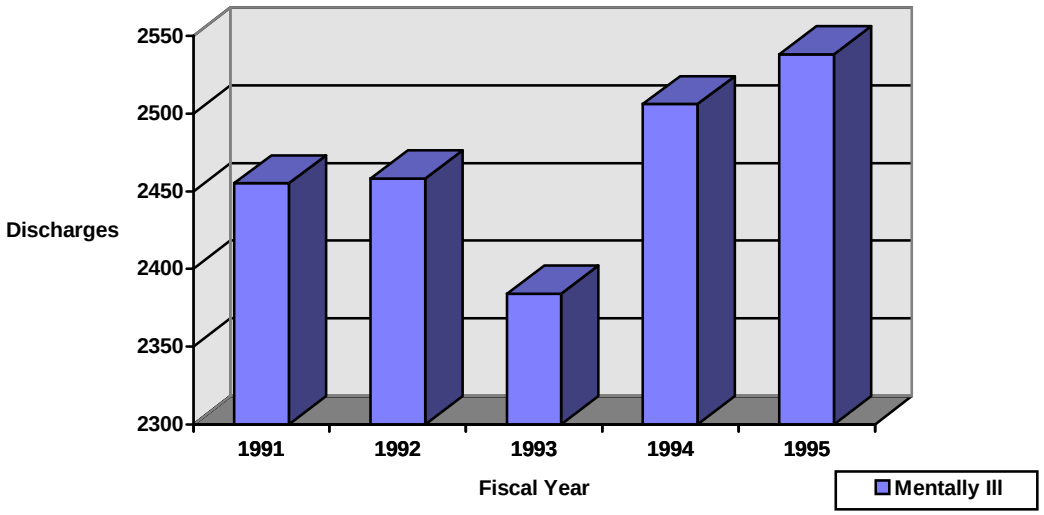
- dual diagnosis care (combined mental illness / substance abuse),
- medications,
- housing / vocational rehabilitation / placement,
- borderline personality program,
- criminal justice diversion program, and
- community outreach and support for psychiatric long term care.

Since a portion of the clients seen have drug/alcohol involvement in addition to mental health issues, the outpatient psychiatry program targeting this population was redesigned and renamed the Harborview Recovery and Rehabilitation Program (HARRP). Twenty-six percent of patients served in outpatient mental health are in the HARRP Program.

Another effort to better integrate mental health services with medical care began in 1994. The Behavioral Medicine Clinic is small and currently undergoing an extensive review to evaluate its focus on psychiatric services for patients in primary care.

Visits/Discharges

Inpatient mental health discharges have remained fairly constant from FY90 to FY95 at approximately 2500, except for 1993.



Outpatient visits for 1995 total 89,877[3]. Patients have multiple intensive services provided at the CMHC in order to reduce inpatient use.

[3] HMHS Activity Report, FY95.

Issues for Services to Mentally Ill Patients

- *Current reimbursement systems for mental health, substance abuse, and medical care, do not support integration of care for multiple diagnoses. For example, if a person has both substance abuse and mental health problems, it is difficult to provide comprehensive care for both problems.*

- *More patients are presenting with multiple problems including substance abuse, medical conditions such as AIDS, criminal justice problems and homelessness. These cases involve multiple systems both within and outside HMC for adequate treatment. Patients often cannot negotiate these complex systems.*

- *The State's plan to "capitate" the Supplemental Security Income (SSI) population, of which 25 percent are seriously mentally ill, could exacerbate the current schism between mental health and primary care providers if funding mechanisms are not better integrated. If both systems are placed at risk for funding, there will be a financial incentive for providers to shift costs between systems.*

- *Although the HARRP is seen as a center of excellence for the most challenging of the mentally ill clients, no funding has been available for addiction treatment, nor extra funding for this highly complex population.*

Substance Abuse

Introduction

The combination of changing County and State policies regarding organization and funding of publicly supported alcohol and drug abuse services and shifts in drug use e.g. more crack and heroin, have had an impact on patients seen at Harborview and services they require. HMC has become more of a de facto "last resort" for the dually or multiply diagnosed i.e. those with mental health, substance abuse and medical care issues, individuals with high medical acuity levels and substance use, and the homeless.

Patient Profile:

SUBSTANCE ABUSE
Samuel W. is a 42-year-old restaurant worker from Lynnwood with an escalating history of drug abuse. Starting in high school with alcohol, he gradually began using marijuana, cocaine and finally heroin, which was encouraged and easily available from his co-workers. After a family intervention a year ago, he quit heroin, changed jobs and began counseling and therapy at Harborview. His employer does not provide health insurance, but with the help of HMC he now is covered by the Basic Health Plan.

Patient Demographics

- *Inpatients at HMC with substance use problems cross all age groups with the majority (89%) being 21-60 years of age.*
- *74% of inpatients seen for substance use are male.*
- *71% of all inpatients have Medicaid as a payor source and 14% Medicare. Fifty percent of inpatients seen at HMC for substance abuse are from central King County.*

Services

HMC offers the following services on-site and at its Pioneer Square Clinic:

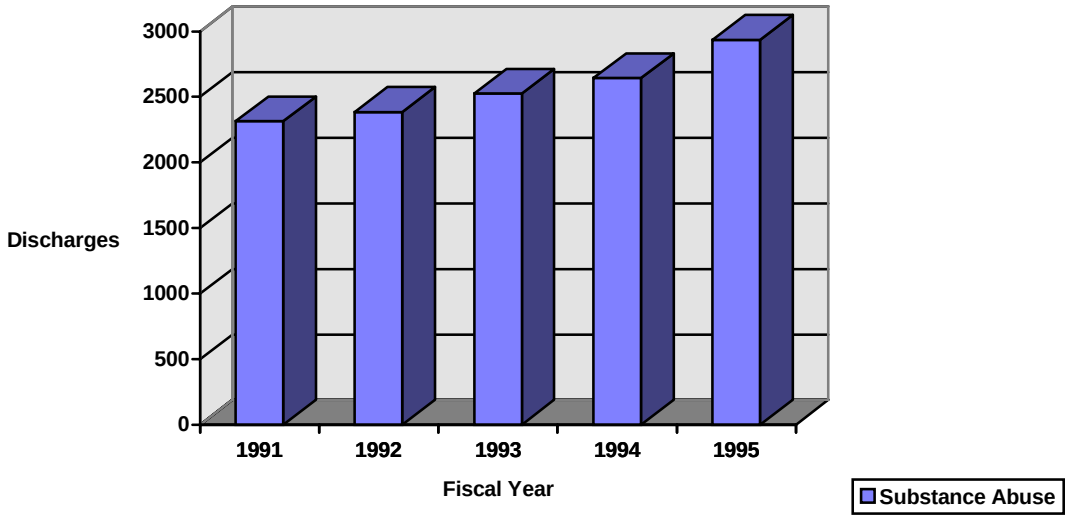
- chemical dependency counseling, and
- individual, family and group therapy.

In addition, the Harborview Recovery and Rehabilitation Program (HARRP) serves clients with drug, alcohol involvement, and mental health issues. HMC is piloting a study to evaluate the effect of early intervention in an inpatient unit on those identified as alcohol or other drug involved. The results of an

FY93 multi-disciplinary task force on substance abuse at HMC recommended that HMC conduct training throughout the Medical Center to increase awareness of drug/alcohol problems, develop standards for a brief assessment and intervention, and improve referral and funding on a system-wide basis by working with agencies outside HMC. Studies suggest that 50 percent of patients with alcohol and other drug problems are not identified with current screening procedures.

Visits/Discharges

The number of inpatient discharges for substance abuse rose by 27% from FY91 to FY95. It is estimated that one quarter of the inpatients are involved with alcohol or other drugs, and a recent study found that 36 percent of trauma patients were legally intoxicated at the time of their accident.



There is not only an increase in the number of inpatient discharges, but a rise in the number of patients with dual diagnoses (see section on Mental Health) and those who are indigent.

Issues for Substance Abuse Services

- *In King County, there is a need for increased numbers of sobering beds and less costly sites of service than the emergency room.*

- *Long term case management is needed by those substance abusers with the most severe conditions. Although only a portion of the general population of substance abusers, this is the most often treated client at Harborview's mental health services. Additional support services are also involved in treatment; e.g., housing or specialized job placement. Medicaid and managed care do not financially support the help that is needed for the care of these clients.*

- *The State ADATSA financial screening and referral is done out of a central location in the County. HMC must refer patients in need of drug/alcohol assessment outside the institution and often loose patient contact. With such a large population of alcohol and drug involved patients, HMC would like to pursue having ADATSA screening on site.*

- *There is a need to modify the involuntary commitment procedures for substance abusers in order to assist them in receiving treatment thereby reducing their risk to themselves and others.*

- *Elimination of SSI benefits to substance abusers who do not have other medical diagnoses as their source of disability will exacerbate an already thin "safety net".*

Sexually Transmitted Diseases/AIDS

Introduction

The **Sexually Transmitted Disease (STD) Clinic** at HMC is a cooperative effort of the Seattle King County Department of Public Health (SKCDPH), Harborview Medical Center and the University of Washington. The STD Clinic is operated by the SKCDPH and has a main location in the hospital and at least five satellite sites throughout the community.

HMC operates the Madison Clinic for treatment of patients who have HIV infection and **Acquired Immune Deficiency Syndrome (AIDS).** This clinic is located at Broadway and Madison. Outreach workers also serve clients in shelters, at the Pacific Hotel and the Pioneer Square Clinic.

U.S. News and World Reports recently named the U.W. (including the HMC programs) as one of the top five U.S. universities for AIDS care and research.

Patient Profile:

AIDS/STD
Andrew Y., a 32-year-old sculptor, was diagnosed HIV positive 14 years ago. Two years ago, his health began to deteriorate rapidly and he devoted fewer and fewer hours to his art. When protease inhibitors became available about a year ago, his doctor prescribed the new drug. Andrew now feels better, and has begun devoting several hours a week to creating sculpture and has shown his work at an exhibition during International AIDS Week. He continues to use the Madison Clinic's support group and therapy programs as well as receiving his treatment there.

Patient Demographics

- *86% of AIDS/STD inpatients are male; outpatient AIDS services are 92% male and STD outpatient services are 62% male.*
- *45% of AIDS/STD inpatients are between 31 and 40 years of age, certainly the largest concentration of individuals in this age category of any priority patients; this largely reflects those patients with AIDS.*
- *Next to jail inmates, HIV/AIDS inpatients have the second highest concentration of all priority patients with Medicaid as a payor source at 75%.*
- *57% of AIDS/STD inpatients are from central King County.*

Services

All new patients seeking **STD services** at the Clinic are tested for gonorrhea, syphilis, chlamydial infection and common STD clinical syndromes. In addition, HIV counseling and testing is routinely offered to those seeking care for STD's. Treatment for STD's and appropriate follow-up is offered.

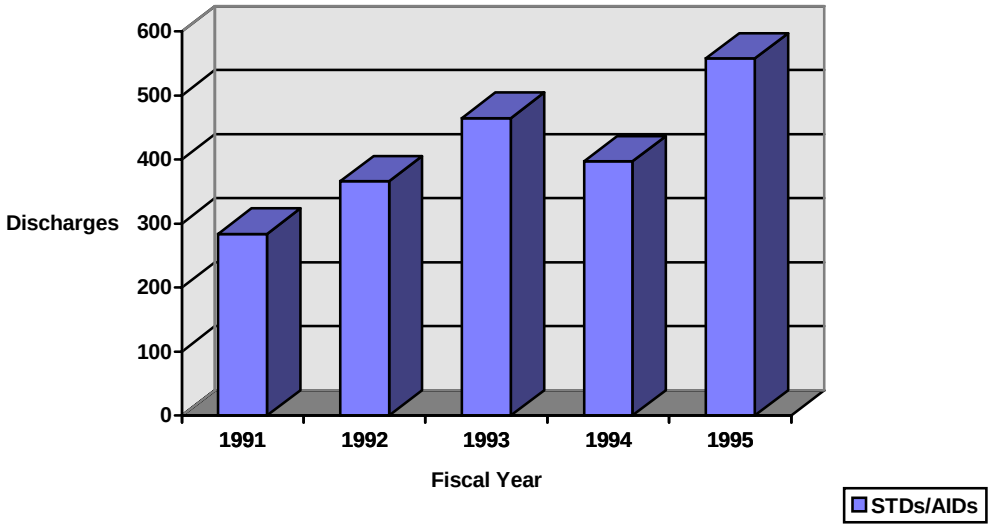
Services for HIV/AIDS at HMC include:

- inpatient and outpatient care,
- respiratory therapy,
- recreational, physical and occupational therapy,
- dental care,
- eye care,
- radiology,
- HIV testing and counseling,
- spiritual care,
- access to clinical trials,
- social work services including case management,
- chemical dependency counseling,
- nutritional assessment, and
- referrals.

Both the STD and Madison Clinics are seeing an increase in more complex cases, and the Madison Clinic is experiencing an increase in numbers of multiply diagnosed cases--those with HIV and mental health and substance use issues. The Madison Clinic is also experiencing an increase in women and minorities. In addressing these trends, the Clinic has non-English speaking providers, utilizes trained health care interpreters and uses the AT&T language line. In addition, it coordinates services with the Northwest Family Center, a Public Health Department program for women and children located in the same building as the Madison Clinic.

Visits/Discharges

Inpatient AIDS/STD discharges nearly doubled from FY91 to FY95, reflecting the increased numbers of HIV/AIDS patients in need of hospitalization.



On an outpatient basis, the Madison Clinic cares for approximately one third of all AIDS patients in King County. In FY95, the Madison Clinic saw 1572 patients in 8469 visits. The STD Clinic experienced 18,359 visits in FY95.

Issues for STD/AIDS Services

- *Significant reductions in public funding for HIV/AIDS and other services*** *emphasizes the need for the county and state to work together in the legislative process to insure critical funding for priority populations.*

  *** This includes Federal CDC funding being given as a block grant to states in FY96 to cover AIDS, STD, and TB resulting in reduced funding levels for all three; potential cuts in Medicare and Medicaid with concern that some groups such as legal immigrants may loose coverage; cuts in federal Ryan White money, a major fund source for primary care, case management and other health and social services to people with AIDS; and a reduction in STD prevention funds.*

- *If managed care is mandatory for SSI, then patients will need to use SSI-approved providers. This could be problematic, if there are not sufficient providers in particular areas to address specialty issues.*

- *The new generation of HIV therapies, protease inhibitors, raise exciting possibilities for improving the health and prolonging the lives of those infected with HIV. At the same time, there are serious concerns about the financial implications of these new drugs for low income patients and the "safety-net" providers who care for them. The cost of the new drugs plus the additional medical cost of care is estimated at $12-18,000 annually per patient. Currently there is not enough funding within the state's HIV Pharmacy Program to cover these increasing costs.*

Domestic Violence and Sexual Abuse[4]

Introduction

The HMC **Sexual Assault Center (SAC)** was established in 1973. It is the largest center addressing sexual assault in the County and the only hospital based site. SAC is located off-site from the medical center and has one satellite, the Eastside Sexual Assault Center for Children (ESACC). This center is located at Overlake Hospital, managed by HMC, and advised by an East King County Citizens Advisory Board. SAC staff not only provide quality treatment but teach health, social services and criminal justice professionals how to address the needs of sexual assault victims.

For the past year, SAC has been participating in a regional planning effort around sexual assault services with the City, County and State. From that effort has emerged agreement on service definitions, accountability and distribution of funds.

While HMC does not have a separate program for **domestic and interpersonal violence**, it does have training in, and protocols for, identification of victims of violence. It also provides services to individuals (e.g. abused children, battered women and elders who are abused and neglected) who have experienced domestic or interpersonal violence.

Patient Profile:

DOMESTIC VIOLENCE/SEXUAL ABUSE
Connie S. is a 21-year-old from Seattle who spent most of her adolescence between a sexually abusive home and foster homes. She began going to the Harborview Sexual Assault Center at age 17 when referred by the Seattle Police after filing a restraining order against her step father. Since then, Connie has been in extensive therapy at SAC. For four years Connie was homeless, in and out of treatment centers and estranged from her family. With the counseling and resource referral that she received at SAC she was able to get her GED, is living in a group home and will start community college in the fall.

Patient Demographics[5]

- 55 percent of patients seen at Harborview Sexual Assault Center and the Eastside Sexual Assault Center for Children are 12 years of age or younger, 14 percent are between the ages of 13 and 17, and 31 percent are 18 years of age or older.

- 45 percent of those seen for counseling at the two centers have Medicaid as a payor source.

[4] Combined because the clinics and services meeting these priority patient's needs do not include demographics and payor category in differentiating between these patients.
[5] Demographic information is not available on victims of domestic violence and interpersonal violence.

Services

At least half of the clients in need of services enter through the **Sexual Assault Center** at HMC or Eastside SACC. Those recently assaulted enter generally through the emergency room (usually within 72 hours of assault). A small percentage of clients come from the Women's or Children's Clinics.

Services available through the Sexual Assault Center and ESACC and the Emergency Trauma Center (under the training and guidance of SAC) include:

- medical exams to evaluate and treat the effects of sexual assault and provide documentation for court and child protection action,
- telephone and in-person crisis counseling,
- ongoing individual and family counseling,
- support and advocacy for clients and families as they seek services from other systems,
- referral and coordination with other community services, and
- training and support for physicians and hospital emergency rooms around evaluation and treatment of sexual assault.

Services provided to victims of **domestic and interpersonal violence** include:

- crisis intervention,
- assessment, medical treatment and follow-up,
- patient education,
- patient advocacy,
- case management, and
- referral to community services and other areas of HMC.

Visits/Discharges

Since the SAC opened in 1973, over 20,000 individuals have used one or more of its services. The service package has changed over time and it is difficult, and perhaps misleading, to compare statistics from year to year. In FY 95, 1361 patients were seen in 5,941 outpatient visits. Data on inpatient discharges are not currently available.

HMC has not kept statistics on the numbers of clients who have been identified as having situations of domestic or interpersonal violence. Clients enter through all areas and programs within the medical center and there is no mandatory reporting of violence for patients between 18 and 55 years of age; those under 18 years of age and experiencing violence are reported to the Child Protective Services while those over 55 years of age are reported to Adult Protective Services. A data collection system for capturing clients seen in domestic violence situations will be developed for FY96.

Issues for Domestic Violence and Sexual Abuse Services

- *Inadequate data collection to identify victims of domestic violence.*
- *Difficulty in locating interventions beyond the "health care system" e.g. housing, counseling, shelters.*
- *Need to continue planning and strengthening regional response and coordination with related systems e.g. mental health and substance abuse system.*
- *Continue to train health care providers to recognize, treat, and appropriately refer victims of sexual abuse and violence.*

Indigent--Self Pay/State Medicaid

Introduction

This population is comprised of low-income patients who are not covered by commercial insurance. Some are eligible for Medicaid and HMC assists in enrolling them. Others receive subsidized care through the State Basic Health Plan and may obtain assistance from HMC in the enrollment process. For those not eligible for these subsidies, the low income allowance program at HMC offers a sliding fee scale so that patients are charged based on their ability to pay; no billing is sent to those whose incomes fall below the lowest level of the scale.

One innovative way that HMC has assisted the indigent population is by paying the monthly premium for those enrolling in the BHP and whose income is below 125% of the poverty level. The state subsidizes the remaining premium and pays the managed care plan the negotiated, capitated rate. HMC sponsors these clients because it is often the small monthly patient premium that keeps low income people from signing up for the BHP and receiving appropriate and timely health care.

Indigent self-pay and Medicaid patients account for the majority of all patients seen at Harborview Medical Center.

Patient Profile:

INDIGENT
Samuel A. is a 23-year-old itinerant worker who has been living in and out of shelters for a couple of years. Being homeless has exacerbated his diabetes to the point where he came to Harborview's Emergency / Trauma Center on several occasions suffering from insulin shock. Recently, the staff at Harborview's Pioneer Square Clinic have convinced him to come for exams and medication on a regular basis. With improved health, he has applied for a job training program while he continues to work temporary assignments.

Patient Demographics

- *73% of indigent inpatients are male, while 61% of indigent outpatients are male.*
- *49% of indigent inpatients are between the ages of 21 and 40, while 31% of indigent inpatients are 20 years of age or younger. Outpatient statistics mirror the inpatient data.*
- *In FY95, approximately half of the indigent outpatients came from central King County.*

Services

Patients without commercial insurance coverage who seek care at HMC have available to them the full range of services offered by HMC, including inpatient and outpatient care and all specialty services.

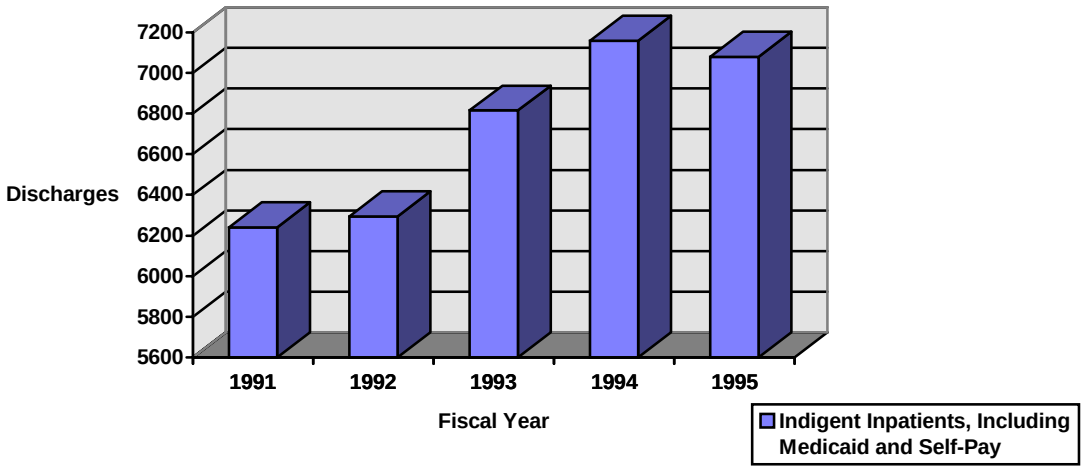
In addition, Harborview's Health Coverage Services Department provides counseling and assistance to patients with no ability to pay or no medical insurance to determine eligibility for Medicaid and Basic Health Plan. Services include explanation of eligibility and benefits information, assistance with completion and submission of application forms and tracking applications and advising the billing department of acceptance into any state program covering health care expenses.

Patients without insurance may not have sought or received appropriate care in the past, so that there may be more medical complications, factors outside of the medical problem that affect the medical outcome e.g. homelessness, poor nutrition, history of mental health or substance abuse issues and more extensive follow-up required. Even those patients with coverage may have limited benefits which affects their overall health status e.g. the Medically Indigent Program covers care only for a 3 month acute episode in a given year. In addition, there may be language or other cultural barriers in seeking care and adhering to medical regimens.

HMC is a "safety net" for many difficult to treat, indigent patients who can not access other systems e.g. mental health and drug treatment, or do not have coverage to initiate and/or continue services in other systems.

Visits/Discharges

From FY91 to FY95, the number of indigent patients (those without insurance, Low Income Allowance, and Medicaid) increased thirteen percent.



In FY95, 39,752 indigent-self pay/Medicaid outpatients were seen in 192,116 visits. This represents 69.9 percent of all outpatient visits at HMC.

Issues for Services to Indigent Patients - Medicaid/ Self-Pay

- *As the number of uninsured or underinsured grows, there need to be a community-wide response to their care. "Safety Net" providers and others in the community need to work together closely to serve uninsured patients.*
- *Maintenance of disproportionate share funding is critical to support "safety-net" services.*
- *Changes in federal and state policy could dramatically affect Medicaid programs in Washington State. Continued funding for the Medically Indigent Program and careful implementation of SSI capitation are critical to the most vulnerable populations.*
- *Basic Health Plan, a state subsidized insurance plan for families below 200% of the poverty level is no longer enrolling new applicants. A reservation/waiting list of over 90,000 individuals exists. Funding for the targeted 200,000 enrollees will be sought this legislative session as an integral part of our state's response to the problem of the uninsured.*

Non-English Speaking Poor

Introduction

HMC offers a centralized interpreter services program that coordinates qualified interpreters from Harborview staff and community agencies. The most common languages provided through HMC's Centralized Interpreter Services include American Sign Language, Amharic, Bahasa, Bulgarian, Cambodian, Cantonese, Chau-Jo, Dari, Farsi, French, Hindi, Hmong, Illocano, Khmu, Lao, Malay, Mandarin, Mien, Oromo, Polish, Punjabi, Russian, Somali, Spanish, Swahili, Tagalog, Tegrinia, Thai, Toisonese, Ukrainian, Urdu, and Vietnamese. Other languages are also available through HMC and the AT&T language Line.

Patient Profile:

NON-ENGLISH SPEAKING POOR
Abuah L. is a 21-year-old widow from Somalia with two young children. She arrived in the United States in 1994, and connected with the Somali community in Central Seattle. Having lost the rest of her family to starvation and warfare in Somalia, she is now utilizing the Interpreter Community Mediators (ICMs) of Harborview's Community House Calls program to better understand and connect with social and health services including Head Start, well child care, OB/GYN services and WIC.

Patient Demographics

- *More non-English speaking males (58%) than females were seen as inpatients and outpatients in FY95.*
- *Non-English speaking individuals seen were spread across all age groups, but had the largest proportion of patients of any priority population group in the age groups 51-60, 61-70 and over 70 years of age.*

Services

HMC has developed two programs to serve the specialized needs of the non-English speaking population--the Refugee Clinic and Community House Calls Program.

The Harborview **Refugee Clinic** has been in operation since 1982. The Clinic began in response to the large influx of Southeast Asian patients following the Vietnam war and related regional conflicts. Since that time, it has expanded its services for the growing number of African, European, Eastern European, and other Asian refugees.

The Refugee Clinic provides primary care for adults (17 years of age and older) through use of bilingual, bicultural staff and interpreters who are able to negotiate the linguistic and cultural differences between western medicine and care utilized in other parts of the world.

The **Community House Calls Program** was started in April 1994 with a grant from the Robert Wood Johnson Foundation to the Refugee and the Children's Clinics. The program funds Interpreter Cultural Mediators (ICM) and Community Advisors who are able to decrease sociocultural barriers to care for non-English speaking ethnic populations by translating and exploring differences in cultures and tradition and educating and supporting the health care team and patient population. The ICM's follow the patient's care from home through the health and social services continuum and back home again. The Community House Calls Program has been recognized as an outstanding community outreach program by several different organizations, including the National Association of Public Hospitals and the American Hospital Association's Foster McGaw award.

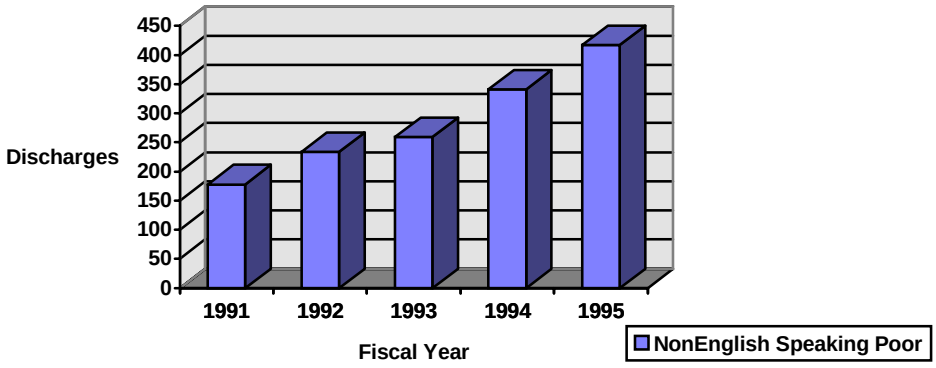
Services include:

- advocacy,
- referral,
- community and patient health education,
- family counseling,
- social support,
- cultural advice to health care providers, and
- assistance and follow-up in clinic and at home.

All non-English speaking patients have counselors available to help them obtain health care coverage if they do not have commercial insurance.

Visits/Discharges

From FY91 to FY95, inpatient visits increased 134 percent for the non-English speaking poor.



In FY95 the number of outpatient encounters for the non-English-speaking poor is estimated to be nearly 20,000. Data describing outpatient encounters has only been collected since January of 1996 so this number has been projected by using January through March of 1996 data.

Issues for Services to Non-English-Speaking, Low-Income Patients

- *An acute sense of isolation, combined with the trauma experienced prior to their arrival in the U.S. and their difficulty in coping with and acclimating to the U.S. culture position the non-English speaking population for mental health problems and intergenerational conflict that severely compromise their health and well-being.*

- *Additional training is needed in HMC and in the community on how to best work with different cultures and understand their health needs, health seeking behaviors and utilization of health care and medications*

- *Communication and coordination could be improved between the House Calls program and other agencies and service providers in the community including the Public Health Department for maternal and child health issues and infectious diseases and traditional healers/physicians in the Rainier Valley who might serve as primary physician for the non-English speaker.*

- *There needs to be a better understanding of the non-financial barriers to care and their effect on the health of the non-English speaking population*

Priority Patient Tables

The following two tables summarize data on Harborview's priority populations. Outpatient data is included for the first time in this report, as reflected in Table 1. Additional information on outpatient activity, particularly in the areas of substance abuse and domestic violence is needed and will be included in future reports.

The second table reflects the trends in Inpatient activity from FY 91 through FY95. Since victims of domestic violence and sexual assault were added as a priority population in 1995, historical data is not available.

Section Two on the cross-cutting issues facing the priority populations follows. It focuses on three key issues that cut across the populations of concern. It is not meant to diminish the issues facing any of the individual populations but merely to respond to the issues raised by the Health Systems and Health Status Task Force and the Task Forces established within it.

Table 1
Priority Patients
Inpatient Discharges and Outpatient Visits
FY 1995

POPULATION	INPATIENT DISCHARGES	OUTPATIENT VISITS
Jail inmates	87	585[6]
Mentally Ill	2,538	89,877[7]
STD	558	18,359
HIV/AIDS		8,469
Substance Abuse	2,935	--[8]
Indigent - Self Pay	336	73,363
Indigent - State Medicaid	6,744	118,753
Non-English Speaking Poor	417	20,000
Burn Patients	422	3,786
Trauma Patients	3,452	44,968
Specialized Emergency Care	472	
Domestic Violence	--[9]	--[8]
Sexual Abuse	--[8]	5,941
Total Number of Priority Patient Visits	**10,429**	**225,387**
Total Discharges/Visits	**12,714**	**307,989[10]**
Priority Patients as a % of All HMC Visits	**82.0%**	**73.2%**

[6] Reflects ETC visits.
[7] HMHS Activity Report, FY95.
[8] Outpatient data not available.
[9] New priority population data not available.
[10] Finance Report, FY95.

Table 2
Priority Patients
Priority Patients - Inpatient Discharges
FY91 to FY95

	FY91	FY92	FY93	FY94	FY95
Jail Inmates	181	232	226	179	87
Mentally Ill	2,455	2,458	2,384	2,506	2,538
Sexually Transmitted Diseases / AIDS	284	366	465	397	558
Substance Abuse	2,314	2,385	2,526	2,645	2,935
Indigent - Self-Pay	265	235	266	286	336
Indigent - Medicaid	5,974	6,059	6,549	6,872	6,744
Non-English Speaking Poor	178	234	259	341	417
Burn Patients	474	440	330	389	422
Trauma Patients	2,686	2,682	2,719	3,173	3,452
Specialized Emergency Care[11]	460	298	319	296	472
Total Priority Patient Discharges	9,454	9,402	9,715	10,143	10,429
Total Hospital Patient Discharges	11,249	11,430	11,936	12,450	12,714
Priority Patients as a Percentage of All HMC Discharges	84.04%	82.26%	81.39%	81.47%	82.03%

[11] Specialized Emergency Care includes patients who received care in an ICU (CICU, MICU, NICU, ICEU), and who did not have a principal diagnosis of burn.